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MAR 75 M A SCHUCKIT, E K GUNDERSON
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SUBTYPES IN NAVAL SERVICE

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M. A. SCHUCKIT

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The Clinical Value of Personality Disorder

Subtypes in Naval Service*

Marc A. Schuckit, M.D.¹

and

E. K. Eric Gunderson, Ph.D.²

Abstract

Personality disorders represent an important segment of psychiatric practice, but the lack of clear criteria for assigning diagnostic subtypes hinders understanding of the etiology and course of these disorders. Variability in demographic, disposition, and outcome characteristics was examined by diagnostic subgroups, year of discharge, and individual hospital for more than 11,000 Navy personality disorder cases. The results were consistent with the hypothesis that diagnostic subtypes for personality disorders presently have limited clinical and prognostic meaning. It was recommended that objective and standardized criteria be established to differentiate personality disorder subtypes and that homogeneous subgroups with relatively uniform prognoses be defined.

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The Clinical Value of Personality Disorder

Subtypes in Naval Service*

Marc A. Schuckit, M.D.¹

and

E. K. Eric Gunderson, Ph.D.²

Personality disorders represent a significant (but unknown) percentage of the health professional's practice. Patients assigned this label usually present themselves in crisis situations — sometimes in the middle of the night — only to drop from treatment before it is completed. They may be difficult cases to manage, often becoming chronic behavior problems unresponsive to treatment.

Despite the fact that personality disorder patients are seen daily in practice, they remain poorly defined clinically. Pritchard in 1788, Pinel in 1809, Schneider in 1932, and Manderson in 1939 all attempted to deal with the concept of abnormal personality but with limited success. None adequately differentiated between concepts of personality disorder as an illness, a behavioral syndrome, or a life style (1-3). The lack of clear thinking about personality disorders does not stem from a paucity of case material, especially in the military where approximately two-thirds of all psychiatric admissions, three-fourths of all psychiatric separations from

service, and one-half of all psychiatric hospital days are attributable to personality disorders (4). One hindrance to understanding the etiology and course of these disorders is the lack of quality control in the use of personality disorder labels (3,5). An evaluation of diagnostic practices in an Air Force mental hygiene clinic revealed that psychiatrists had strong diagnostic biases which resulted in "a disturbing lack of clarity in the symptom patterns associated with diagnoses as related to guide definitions" (6). Personality disorder labels seem to be used descriptively by most clinicians to indicate subjective views of clinical status at one point in time rather than as firm diagnoses with etiologic, diagnostic, or therapeutic implications (2).

With few exceptions there are as yet no clearly defined personality disorder subtypes (7). Some investigators have attempted to remedy this problem by working within the framework of the Diagnostic and Statistical Manual of the American Psychiatric Association (8).

Snell and associates (9) described the Passive-Aggressive personality but the diagnostic criteria were unclear and the syndrome outlined overlaps with Primary Affective Disorder, Hysteria, and Alcoholism as described by Woodruff and associates (10) and Feighner and associates (11). In addition, at least 8 percent of the patients in Snell's study were schizophrenic. In a similar manner, Munro (12) gives a thorough description of the inadequate personality but establishes no prognostic or therapeutic importance for the concept.

Other authors have tried to find alternative diagnostic subtype schemes

but with varying success. Walton (2,3) has suggested a dimensional (non-categorical) system for classifying deviant personalities, but the reliability and clinical significance of this model have not been established.

Edwards and Berry (13) used multivariate statistics to establish prognoses for personality disorder cases but discovered that patient characteristics other than diagnostic label were the best predictors of future course.

Feighner and associates (10,11), defining Antisocial Personality in terms of the occurrence of objective events, outlined a group of patients with similar clinical features and relatively uniform prognoses. The entity thus defined is familial in occurrence, has a known natural history and remains distinct from other diagnostic categories on long-term follow-up. A similar scheme, based on the occurrence of pre-defined life events, has been used to establish the definition of the syndrome of Hysteria or Briquet's Syndrome (11,14) with equally promising results.

The Armed Services make frequent use of Personality Disorder diagnoses (6,13, 15-22). The characteristics of servicemen assigned Personality Disorder labels have been fairly well-established and the reasons for the preponderance of those diagnoses in the military have been explored, but the actual descriptive and prognostic meanings of the subtypic labels are unknown. This is of importance for civilian patient populations as well as military because most service physicians are "civilian soldiers" who use their prior training to make diagnoses in the service and then carry back to civilian life the habits acquired while on military duty.

One consequence of imprecise diagnostic habits is that personality dis-

order labels are misused for administrative purposes. The more unclear the diagnostic criteria, the more subjective diagnosis becomes. Ill-defined syndromes invite the use of interpretations more useful to the institution than to the patient. In civilian practice, the personality disorder patient often is felt to be a "trouble-maker" and the diagnosis may be taken as a warning to "beware" by future health workers. In the military service the labels are often used as administrative reasons for discharging troublesome soldiers or sailors (6,16, 19-22).

Thus, we can see that Personality Disorder diagnoses are loosely defined labels, used imprecisely by both civilian and military health workers; potential dangers to the individual patient of inappropriate clinical or administrative actions are quite real.

This investigation will view the use of Personality Disorder labels in the military service from the vantage point of Feighner and associates (11) and Woodruff and associates (10). A service population is appropriate because of the high incidence of Personality Disorder diagnoses and the assessability of hospitalization and follow-up records. The question to be addressed is: Do Personality Disorder subtypes have sufficient descriptive or prognostic meaning to justify their continued use?

Method

The present study included 11,549 Navy enlisted inpatients who received primary diagnoses of Character and Behavior Disorder at the time of discharge from naval hospitals during Calendar Years 1966-1969. The psychiatric files from which these data were extracted have been described by Gunderson (23).

The general rubric Character and Behavior Disorder has since been replaced by the term Personality Disorder. Patients with diagnoses of Alcoholism, Drug Addiction, or Sexual Deviation were excluded from consideration in order to achieve a more homogeneous patient population. Diagnoses were assigned with reference to the Department of Defense Disease and Injury Codes (24) which are similar to the categories used in the Diagnostic and Statistical Manual of Mental Disorders, First Edition, of the American Psychiatric Association (8). For cases with multiple admissions during the period of the study, data were extracted from the first inpatient record. Only cases with primary Personality Disorder diagnoses at the time of discharge from the hospital were used; cases with secondary or tertiary Personality Disorder diagnoses only were not included. Diagnoses were assigned by physicians, usually psychiatrists, and reflected general medical training and experience; as a rule no special training in the diagnosis of Personality Disorders had been received in military settings.

Demographic and clinical characteristics of patients in the six most populous diagnostic subtypes were examined; Antisocial and Dyssocial Personality categories were combined because of small numbers and clinical similarities. The remaining personality disorder subtypes were combined into a single group.

Patient characteristics at the five naval hospitals with the largest numbers of personality disorder admissions were examined separately and samples from two overseas hospitals (F and G) and from two small hospitals in the same region of the continental United States (H and I) were combined for

purposes of comparison in Table 2. The remaining hospitals and dispensaries were grouped under the "Other" category.

Demographic, diagnostic, disposition, and outcome characteristics were examined from three perspectives. In Table 1 patients were divided into diagnostic subgroups using personality disorder patients in all major or minor treatment facilities. Second, patient characteristics were examined by year of discharge for the six largest hospitals only, each of which had a stable census. In Table 2 patient characteristics were examined for differences among major hospitals. Frequency distributions were obtained for all variables and groups and the chi square statistic was computed where appropriate.

Psychiatric and service histories of all patients were followed to January 1, 1972, using computer tapes provided by the Bureau of Medicine and Surgery and the Bureau of Naval Personnel. Patients were considered returned to duty, and, therefore, eligible for determination of post-treatment success or failure, only if they remained in service 6 months after release from the hospital. The patients were considered successful in their post-hospital adjustment if they completed at least 6 months on active duty and were not rehospitalized and, if separated from service after 6 months, they received favorable types of discharges and were recommended for re-enlistment. Patients who completed less than 6 months of service after release from the hospital were dropped from the analysis — this category represented only about 5 percent of the sample. Men were considered failures if after 6 months they were rehospitalized, received unfavorable discharges, or received recommendations against re-enlistment.

Results

Diagnostic subtypes were compared in Table 1. The groups were quite similar demographically: young men with short service histories and low pay grades, typically unmarried, Caucasian, and scoring slightly below the Navy average on the General Classification Test (GCT). Minor exceptions were the over-representation of women and non-Caucasians in the Hysterical group; the youth, short service, low pay grade, and low GCT performance of those in the Inadequate category; the older age and longer service of the Passive-Aggressive/Passive-Dependent patients, and the higher GCT scores of the Schizoid group. Percentage married generally paralleled age for the various groups, except that the Emotional Instability group had a higher percentage married than would be expected from their young mean age.

While the diagnostic subtypes were generally similar in demographic characteristics, there were large differences among subtypes on treatment and outcome variables. Percentages referred to Medical Boards for evaluation -- generally reflecting severity of condition -- ranged from 22 percent for the Hysterical group to 54 percent for the Schizoid group. The rate of return to duty from the hospital varied from 55 percent for the Other and Unspecified (Hysterical, Sociopathic) group to 26 percent for the Schizoid group. The mean length of hospitalization varied from 22 days for the Hysterical group to 39 days for the Schizoid group. The rate of post-hospital success differed widely from 10 percent for the Antisocial/Dyssocial to 43 percent for the Passive-Dependent group. This disparity in treatment and outcome variables could reflect prognostically distinct subgroups. If there is consistency in such differences over time and among hospitals, clinically mean-

ingful diagnostic subtypes would be suggested.

To test consistency in diagnostic and treatment practices over time, demographic and diagnostic characteristics and dispositions and outcomes for all personality disorder patients at six combined major naval hospitals were examined for each of the 4 years of the study. Demographically the patients showed little variation over the 4 years: mean ages ranged from 20.8 to 21.2, mean years of service from 2.0 to 2.8 years, mean pay grades from 2.7 to 2.9, the percentage of women from 2 percent to 3 percent, percentage Caucasian from 94 percent to 95 percent, and percentage single from 71 percent to 78 percent.

Despite the stability in demographic characteristics over the 4 years, diagnoses, dispositions, and outcome varied considerably over the same time span. The percentage of patients diagnosed Emotional Instability varied from 18 to 36 percent; the percentage classified Other and Unspecified (Compulsive, Immature) ranged from 8 to 20 percent; the percentage referred to Medical Boards varied from 34 percent to 50 percent; the rate returned to duty from 86 percent to 50 percent, and the success rate of those returned to duty from 85 percent to 42 percent. Thus, while the demographic characteristics of personality disorder patients remained relatively constant over the period of the study, the distributions of diagnostic subtypes, disposition decisions, and treatment outcomes varied from year to year.

Another view of the problem is provided in Table 2 where the patient characteristics and clinical practices at major hospitals were compared. Except for Hospitals F and G, these were general medical hospitals located in the continental United States. Hospitals B and E are noteworthy because of their proximity to recruit training centers. Once again, patient populations

tended to be homogeneous in demographic characteristics across hospitals. Hospital E, located near a recruit training center, had a younger population with shorter service and fewer married than other hospitals, but other demographic differences were minor.

At the same time, treatment and outcome characteristics differed widely among hospitals. First, it was apparent that the overseas hospitals (F and G) handled patients quite differently from hospitals in the continental United States: length of hospitalization was much shorter (13.9 days), many more were returned to duty from the hospital (66 percent), and fewer were referred to Medical Boards (8 percent). Omitting the overseas hospitals from consideration, differences among the remaining U.S. hospitals were still sizable. Despite similar patient characteristics, Hospital A referred 58 percent to Medical Boards while Hospital D referred only 26 percent, and Hospital E referred 42 percent compared to 25 percent for Hospital B. Percentages returned to duty among the U.S. hospitals varied from 25 percent for Hospital C to 42 percent for Hospital E. The average length of hospitalization for U.S. based facilities varied from 23 days to 45 days. Success rates for men returned to duty ranged from 33 percent to 43 percent.

Again omitting overseas hospitals from consideration, differences in diagnostic practices were dramatic: percentages diagnosed Emotional Instability varied from 38 percent at Hospitals H and I to 17 percent at Hospital G; percentages Passive-Dependent varied from 31 percent at Hospital H and I to 45 percent at Hospital C, and the remaining categories combined varied from 7 percent at Hospitals E, H, and I to 20 percent at Hospital C.

Discussion

Personality disorders occupy a large percentage of the health professional's time but remain basically undefined. Over the 4 years of this study, more than 11,000 personnel were hospitalized with personality disorder diagnoses. In general, these men were young, relative newcomers to the service, and slightly inferior to their service peers on General Classification Test scores. Once hospitalized they stayed as inpatients for about a month and tended to be unsuccessful if returned to duty. They represented a great expense to the service in hospital days (432,000 days in 4 years), missed work time, and wasted training. In spite of the magnitude and cost of the problem, personality disorder patients have not been thoroughly studied.

One attempt to define personality disorder involves the assignment of patients to subtype categories. The naval service follows the civilian practice of assigning diagnostic subtypes based upon the very limited criteria presented in the Diagnostic and Statistical Manual of Mental Disorders, First and Second Editions. The data presented in this paper can be used as a measure of the usefulness of the subtype diagnostic scheme, applying the yardstick suggested by Feighner and associates (11) and Woodruff and his associates (10), that is, the usefulness of these diagnostic categories is gauged by their ability to define homogeneous subgroups with relatively uniform prognoses.

Tables 1 and 2 revealed that men with similar demographic characteristics who served in similar environments (mostly continental U.S. facilities) received different care and experienced different dispositions and outcomes after treatment. From Table 1 alone one might infer that certain clinical

characteristics other than basic demography were used to assign subtype labels which, with the exception of Antisocial/Dyssocial cases (representing only about 1 to 2 percent of the personality disorder patients), have a moderate variability in rates of success once returned to duty (33 percent to 43 percent) and wide variations in other administrative and outcome variables. However, there was no strong correlation between success rate and percentage returned to duty, average hospital stay, or percentages referred to Medical Boards. If valid and consistent criteria were being utilized for patient classification and treatment and administrative decisions, one would expect better correlation among these factors.

Variations were also seen when patterns were compared over the 4 years of the study — the demography remained stable while the administrative and outcome characteristics varied markedly. It is unlikely that an entirely new type of patient entered care, especially in view of the fact that the descriptive characteristics were so constant. Between 1967 and 1969 there was a large decrease in the proportion of men being sent to Medical Boards, an increase in the rate of return to duty, but a decrease in the percentage of success. These changes showed no clear relationships to diagnostic patterns.

Table 2 tends to corroborate the relative independence of diagnosis and outcome. Hospitals serving similar populations had patients with similar demographic characteristics. Yet these same institutions showed wide variations in diagnostic distributions and administrative practices for patients and moderate variations in post-hospital success rates. The data are thus

consistent with the hypothesis that diagnostic subtypes for personality disorders have limited clinical and prognostic meaning. Descriptively this rubric falls far short of the ideal as patient populations with different labels have similar demography. Disposition seems to vary more by year or by hospital than by diagnosis. It appears that the diagnostic label assigned may reflect the idiosyncratic preference of the particular physician at one point in time rather than the clinical picture or prognosis of the patient.

Personality disorders represent an important segment of clinical practice, and it is suggested here that our level of understanding of the course of these disorders might be enhanced by standardizing diagnostic labels through implementation of objective definitions. Retrospective follow-up studies such as those conducted with the Antisocial Personality (10,11,25) and Hysteria (10,11,14) could be applied to other personality subtypes, and when patients enter treatment in the future, clinicians could better evaluate probable course and choose the appropriate therapy.

One diagnostic subtype, Antisocial Personality, has been shown in other studies (25,26) to have descriptive and prognostic validity. This label depicts an individual, usually a man, who prior to age 18 begins to evidence antisocial problems in every area of his life. Once the process begins (regardless of the cause) long-term follow-up studies have shown the person to have a high rate of death by homicide or suicide and that he is likely to spend the majority of his adult life in prisons. The criteria for this diagnosis are explicit and based upon objective occurrences rather than upon underlying dynamics. It is of interest that in the present study Antisocial Personality perhaps was most stable in incidence, demography, and prognosis

over the years and among hospitals, even though the label was probably loosely applied by physicians not following the more rigid criteria referred to above. The homogeneity of this diagnostic group might have been even more evident had standardized criteria been used.

Conclusions

Personality disorders are difficult to define, but almost all clinicians feel that they exist as meaningful entities. There may be subtypes that carry descriptive, prognostic, and therapeutic meanings but with a few exceptions these have not yet been delineated. Because nebulous and non-standardized labels confuse the clinical picture and invite the misuse of psychiatric diagnoses for administrative purposes, the following suggestions are offered.

(1) A standard set of criteria for the general diagnoses of Personality Disorder should be established. These criteria should be clear and based upon objective events, leaving little room for subjective interpretation and enabling different physicians to use these labels in the same manner. It is suggested that these criteria be instituted but considered experimental until family and clinical history studies and follow-up establish the validity of the criteria in the light of the suggestions of Fighner and his associates (11). The criteria should be derived from carefully analysed data reflecting prognostic meanings of a number of current definitions. A good place to begin might be to attempt to clarify the general definition of personality disorders given on pages 41-42 of the Diagnostic and Statistical Manual for Mental Disorders, Second Edition, perhaps following the approach outlined by

the American Psychiatric Association's criteria sets for Professional Services Review Organizations (27).

(2) The diagnosis of Antisocial Personality should be used but only when the established standardized criteria have been considered.

(3) Methods should be explored for subdividing personality disorder patients into relatively homogeneous groups with similar demographics, prognoses, and responses to treatment. Prognoses for various groupings of personality disorder patients in the Navy have been reported in a recent study (28). In the interim all patients with personality disorder labels, other than Antisocial, might be labeled personality disorder not otherwise specified.

Both past research and the present investigation indicate that the existing criteria for personality disorder diagnoses and assignment to subtypes are inadequate (29). Vague definitions and arbitrary assignment of subtypes have encouraged their misuse for administrative purposes. Subtypes in their present form may reflect more of a moral judgment than a careful medical opinion. It has been the purpose of this paper to underscore the problems of the existing system and to suggest possible means for remedying the situation.

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Footnotes

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Table 1

Patient Characteristics and Treatment Variables for Major Personality Subtypes

Pathological Personality							Immature Personality	
Variable	Schizoid	Inadequate	Antisocial/ Dyssocial	Other/Unspecified (Hysterical)	Emotional Instability	Passive Dependent	Other Categories	
Mean age	20.9	20.7	20.9	21.3	20.7	21.8	20.9	
Mean years of service	2.0	1.8	2.6	2.5	2.2	3.1	2.3	
Mean pay grade (rank)	2.8	1.4	2.6	2.8	2.7	3.0	2.8	
Mean GCT	56.0	48.4	51.3	52.9	52.7	53.3	53.2	
Race (%):								
Caucasian	95	96	93	88	96	93	94	
Negro	4	4	7	11	4	6	5	
Other	0	0	0	1	0	1	0	
Sex (%):								
Male	98	99	99	93	97	98	97	
Female	2	1	1	7	3	2	3	
Marital Status (%):								
Single	84	83	83	80	74	69	76	
Married	15	16	15	19	25	30	24	
Other	1	1	2	0	1	1	1	
Medical Board (%):								
Returned to Duty (%):	26	31	44	55	35	41	42	
Success (%):	37	41	10	31	36	43	39	
Mean Hospital Days:								
Number of Cases:	1687	483	163	312	3076	4108	1720	
% of Cases	14	4	1	3	27	36	15	

Table 2

Patient Characteristics, Diagnosis, and Treatment Variables
for Major Naval Hospitals

Variable	Hospital							Hospitals Other
	A	B	C	D	E	F/G	H/I	
Mean age	21.8	21.4	20.8	20.8	20.4	21.3	20.6	21.5
Mean years of service	3.3	2.6	2.3	2.3	1.6	2.6	2.2	2.7
Mean pay grade	3.1	2.7	2.8	2.8	2.2	2.8	2.8	3.0
Mean GCT	54.1	52.8	52.2	54.0	55.1	51.2	53.1	53.8
<u>Race (%)</u> :								
Caucasian	94	94	94	94	96	90	95	95
Negro	5	5	5	6	4	8	5	5
Other	1	1	0	0	0	2	0	0
<u>Sex (%)</u> :								
Male	99	99	98	95	96	100	99	97
Female	1	1	2	5	4	0	1	3
<u>Marital Status (%)</u> :								
Single	68	74	72	75	83	82	78	74
Married	30	25	26	24	16	18	21	25
Other	2	1	1	1	0	0	0	1
<u>Diagnosis (%)</u> :								
Schizoid	17	11	13	15	11	8	19	18
Inadequate	4	5	2	3	6	6	2	4
Antisocial/Dyssocial	1	1	1	2	2	1	1	2
Other (Hysterical)	2	2	1	1	5	6	1	2
Emotional Instability	22	28	17	34	25	25	38	32
Passive Dependent	40	40	45	32	44	27	31	31
Other categories	13	12	20	12	7	27	7	11
<u>Medical Board (%)</u> :	58	25	43	26	42	8	57	44
<u>Returned to Duty (%)</u> :	37	42	25	30	38	66	24	38
<u>Success (%)</u> :	33	38	43	43	40	37	37	41
<u>Mean Hospital Days</u> :	43.2	31.6	33.1	41.0	35.4	13.9	39.1	36.0
<u>Number of Cases</u> :	1245	1175	1934	1086	734	541	1160	2325

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